

Evaluation of the services provided under the Protection of Children Abusing Drugs Act

SUMMARY REPORT

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Alberta Alcohol and Drug Abuse Commission (AADAC)

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Citation of this sources is appreciated

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Executive summary

The Protection of Children Abusing Drugs (PChAD) Act and the services directed by it are in response to a community-identified need resulting in the implementation of a new program that is linked to research and best practices. This report briefly introduces the services and related information on court-ordered addiction services. It describes the methods used in the evaluation, and summarizes evaluation findings for the first year of services along with implications and recommendations. Finally, conclusions and next steps for continuing evaluation efforts are presented.

The Protection of Children Abusing Drugs (PChAD) Act was passed by the Alberta legislative assembly in May 2005. The act came into effect July 1, 2006. Prior to this time, there was no authority to require services for children under the age of 18 who declined voluntary addiction treatment services.

The purpose of the act is to give parents and guardians a new option to help their child under the age of 18 whose alcohol or other drug use has caused significant physical, psychological or social harm to themselves, or physical harm to others, and who are refusing voluntary addiction treatment services. The act allows a parent to apply for a court order to confine the youth for a period of not more than five days to a protective safe house (PSH) for detoxification, assessment and development of a discharge treatment plan.

A brief overview of the literature on the outcomes of mandated treatment was conducted in 2006 in an attempt to provide information to guide evidence-based practices (AADAC, 2006b). Observations from the literature include the following:

- Limited research exists examining mandatory treatment of addictions, especially among youth.
- Results from 30 years of published literature on the effects of mandatory treatment are inconclusive.
- Motivation to change may be more important than coercion when dealing with substance abuse.
- Legal pressure may enhance motivation to change.
- Mandatory substance abuse treatment may reduce criminal activity among youth.

Evaluation methods

The purpose of the evaluation was to

- determine the effectiveness of implementing the services provided under PChAD
- evaluate the outcomes related to impact and effectiveness of the services
- provide recommendations to AADAC for the continued development and implementation of PChAD

To meet this purpose, Pivotal Research conducted the evaluation in three stages:

- An evaluability assessment identified the feasibility of providing information to examine expected outcomes of the evaluation.
- A formative evaluation assessed service effectiveness and areas for improvement to ensure the program was implemented as intended.
- A summative evaluation assessed the outcomes of the PChAD program from a client, clinical practice and management perspective.

From the evaluation findings of these three stages, recommendations were made for improving the program and achieving expected outcomes. A final technical report was produced from the evaluation (Pivotal Research Inc., 2007).

Highlights of findings

This evaluation began with the start of the services and followed through the first year of implementation. As a result, it was expected that areas for improvement would be identified. The program areas addressed these issues as they arose and made significant improvements to the program delivery.

In its first year of implementation, the program made great strides in providing assessment and information in a mandated treatment setting, as indicated by high satisfaction levels of both parents and youth. As well, many youth continued further treatment in voluntary services and reported an improved quality of life in areas such as relationship with family, health, use of free time, school situation and legal situation.

Key findings are organized by four themes:

- awareness, understanding and access
- implementation of PChAD services
- value of PChAD services
- program delivery of PChAD services

Awareness, understanding and access

Because the PChAD program is a parent-driven service, measures of awareness, understanding and access were gathered from parent observations.

- Seventy-seven per cent of parents were aware of the intent of PChAD.
- Of those parents whose expectations did not fit with the program intentions of PChAD, almost two-thirds (64%) also reported that the program did not meet their expectations.
- The majority of parents perceived services provided through PChAD as responsive, in terms of access to counsellors at the PSH and the 1-888 line.
- The majority of parents perceived services provided through PChAD as timely.

Implementation of PChAD services

Measures of implementation of PChAD services were gathered from youth and parent feedback on three items: intake procedures, assessment procedures and treatment plan development.

The majority of parents and most youth were satisfied with intake procedures.

- Parents were moderately satisfied and the majority of youth were satisfied with assessment procedures.

- Seventy-seven per cent of parents were involved with treatment plan development, and 63% were involved with follow-up.
- Though youth were moderately satisfied with treatment plan development, significant proportions of parents were dissatisfied with treatment plan procedures.
- As parent involvement in the treatment planning process decreased, satisfaction with the treatment planning process also diminished.

Value of PChAD services

The value of PChAD services was measured through multiple questions relating to safety, overall service satisfaction, quality of life and family reconnection.

- The majority of parents were satisfied with their child's safety while at a PSH.
- Most parents were satisfied with the services initially provided through PChAD, but satisfaction dropped off over time.
- Eighty-five per cent of youth would recommend the services to friends or relatives in need.
- The majority of youth were satisfied with the services provided at discharge; this was sustained over time.
- Fifty-eight per cent of youth indicated an improvement in their quality of life one month after discharge, and this percentage continued to increase over time.
- More than half of youth reported having a better relationship with their family following discharge.
- A key finding was that about half (49%) of youth who participated in the evaluation reported seeking treatment voluntarily after leaving the PSH.

Program delivery of PChAD services

Program delivery was assessed in this evaluation by the following outcomes: youth apprehended and transported safely to a PSH, assessment completed in up to five days, transition plan in place after assessment, and parent provided an opportunity to engage in additional support after youth discharge. The evaluation provided insight into the length of stay, legal system role and confidentiality provisions.

- Youth were transported safely to the PSH; however, there was some confusion about roles and responsibilities regarding transportation.
- Assessment could be completed in five days, except when a youth was admitted on a weekend or required more time for detoxification.

- About half the staff indicated that there was enough time to develop a discharge plan after assessment.
- Parents were not satisfied with the availability of treatment or other support in the community for youth and families to continue treatment after the youth was discharged. Parents indicated a need for more resources and more information about them.

Conclusions and implications

Overall, the services administered under the Protection of Children Abusing Drugs Act were successful in providing another option to parents in their efforts to support youth dealing with substance use problems. In its first year of implementation, the program made great strides in providing assessment and information in a mandated setting, as indicated by high satisfaction levels among both parents and youth. As well, many youth continued further treatment in voluntary services and reported an improved quality of life in areas such as relationship with family, health, use of free time, school situation and legal situation.

The evaluation identified areas for improvement, including parent satisfaction with treatment plan procedures, transportation of the youth to the protective safe house, and providing parents with an opportunity to engage in additional support after discharge. The program outcomes and recommendations identified in this evaluation report will be used for the ongoing implementation of the provision of PChAD services.

Introduction

The Protection of Children Abusing Drugs (PChAD) Act and the services directed by it are in response to a community-identified need resulting in the implementation of a new program that is linked to research and best practices. This report briefly introduces the services and related information on court-ordered addiction services. It describes the methods used in the evaluation, and summarizes evaluation findings for the first year of services along with implications and recommendations. Finally, conclusions and next steps for continuing evaluation efforts are presented.

AADAC and the Protection of Children Abusing Drugs Act

The Alberta Alcohol and Drug Abuse Commission (AADAC) is a Crown agency of the Alberta Government. AADAC operates and funds programs and services that address problems related to alcohol, other drugs and gambling. AADAC's mission is

Making a difference in people's lives by assisting Albertans to achieve freedom from the harmful effects of alcohol, other drugs and gambling

(AADAC, 2006a)

Operating for over 55 years, AADAC provides services in three core business areas: information, prevention, and treatment (AADAC, 2006a).

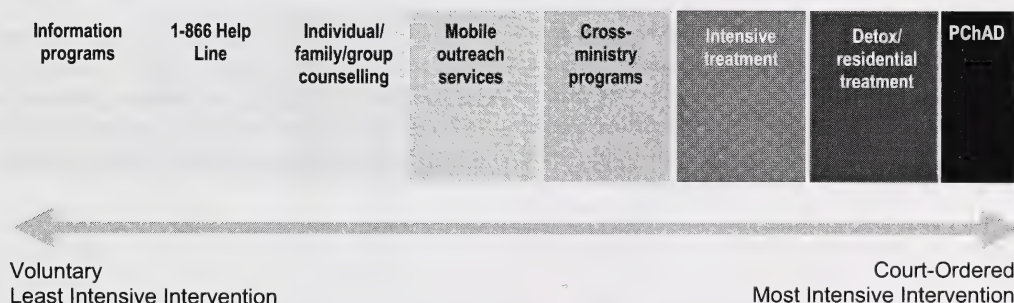
- **Information:** Current and accurate information on alcohol, other drugs and gambling, and on AADAC and its funded services, is available in print and online. A variety of resource materials (e.g., brochures, booklets and information sheets) are available to clients, parents, teachers, allied professionals and the public through AADAC's provincewide service network, and through the website at aadac.com
- **Prevention:** Community-based programs and services are designed to prevent alcohol, other drug and gambling problems. Strategies are intended to build on strengths by increasing protective factors and reducing risk factors associated with substance abuse and problem gambling.
- **Treatment:** AADAC provides a broad spectrum of programs and services that assist Albertans in their recovery from alcohol, other drug and gambling problems. Services include community-based outpatient counselling, day programs, and short-term and long-term residential treatment services that provide a structured environment to assist clients in their recovery. Crisis services include detoxification, emergency counselling, referrals and overnight shelter. Specialized services are available for youth, women, Aboriginal Albertans, business and industry referrals, and people with opioid dependency or cocaine addiction.

Prior to 2005, AADAC's continuum of youth treatment services included information, outpatient counselling, mobile outreach, and day treatment programs with residential support. Over the past few years, AADAC's continuum of services has continued to expand to meet the needs of Albertans. Most notable was the expansion of youth services in 2005 to include residential detoxification and stabilization programs, as well as 12-week residential treatment programs. AADAC now provides detoxification and stabilization programs in Edmonton (four beds) and Calgary (six beds), as well as residential treatment programs in Edmonton (eight beds), Calgary (10 beds) and Lethbridge (eight beds).

Court-ordered youth services

The expansion of youth services continues in AADAC with the newest addition to the continuum of youth services occurring in 2006. Figure 1 shows the current continuum of youth services in AADAC.

Figure 1: AADAC youth services continuum



¹ Each client can report more than one reason for treatment, receive more than one type of treatment or report using more than one type of substance. Therefore, percentages may total more than 100%.

The Protection of Children Abusing Drugs (PChAD) Act was passed by the Alberta legislative assembly in May 2005. The act came into effect July 1, 2006. Prior to this time, there was no authority to require services for children under the age of 18 who declined voluntary addiction treatment services.

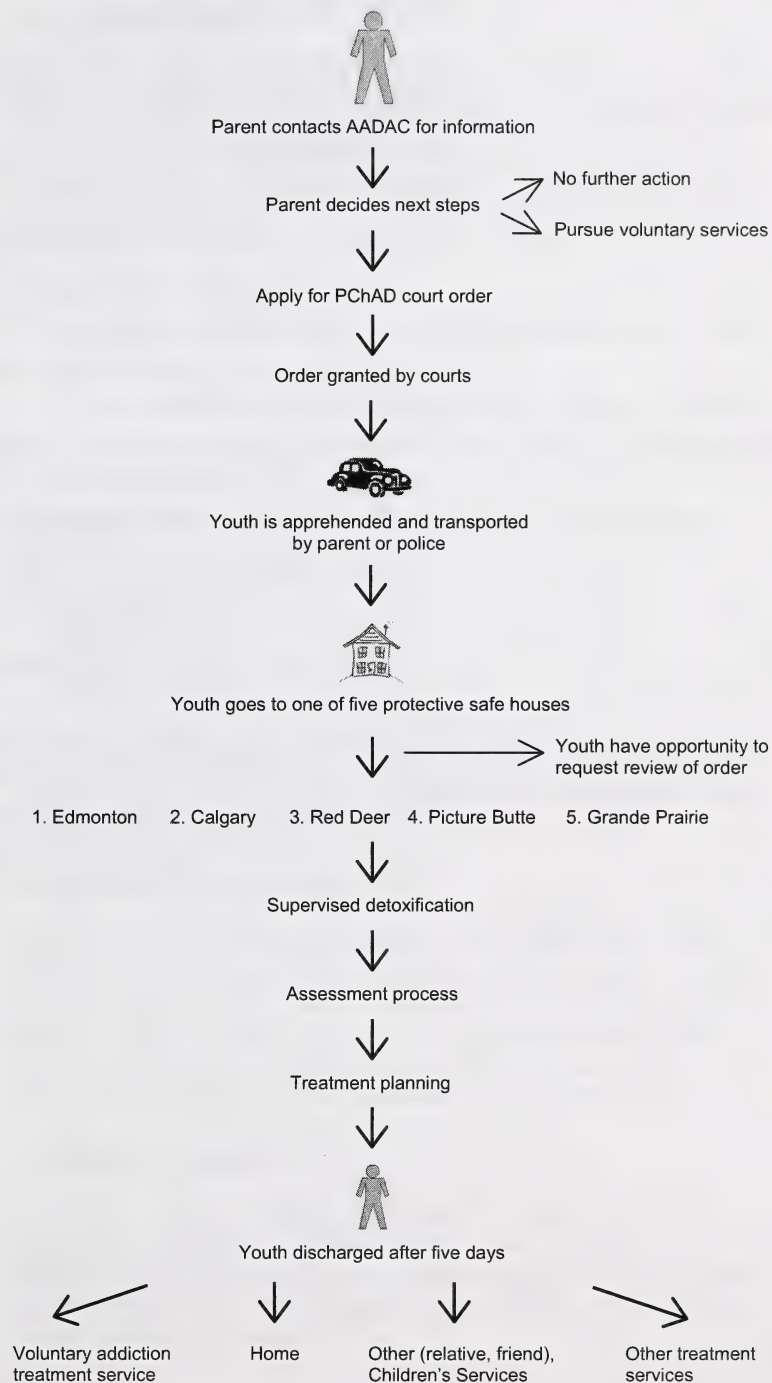
The purpose of the act is to give parents and guardians a new option to help their child under the age of 18 whose alcohol or other drug use has caused significant physical, psychological or social harm to themselves, or physical harm to others, and who are refusing voluntary addiction treatment services. The act allows a parent to apply for a court order to confine the youth for a period of not more than five days to a protective safe house (PSH) for detoxification, assessment and development of a discharge treatment plan. The parent may convey the youth to the PSH or, in situations when that is not possible, the court may authorize police to apprehend and convey the youth to the PSH.

Because the majority of children receiving PChAD services are between the ages of 14 to 17, they are often referred to as youth. Though the act refers to both parents and guardians, in this report "parents" also includes guardians.

There are five protective safe houses in Alberta. They are located in Edmonton, Calgary, Red Deer, Picture Butte and Grande Prairie. The protective safe houses opened July 1, 2006, with the exception of the Grande Prairie house, which opened December 18, 2006. Each PSH has a combination of AADAC staff and PSH staff, whose exact numbers and roles vary across locations. PSH staff generally include program managers, team leaders, house parents, and child and youth workers. AADAC staff generally include a manager, counselling supervisor and addictions counsellors. As well, there are nine mobile AADAC workers located in St. Paul, Camrose, Medicine Hat, Whitecourt, Athabasca, Brooks, Barrhead, Cold Lake and High Level. Mobile workers provide information to the community and parents, and counselling to youth after discharge from a PSH.

Once in the PSH, the youth receives supervised detoxification and AADAC completes an assessment of the youth's alcohol and other drug use. The goal of the assessment is to evaluate the severity of substance abuse by identifying patterns of use and harmful effects of that use on the youth's major life areas. Staff work with the youth and family to develop a discharge treatment plan based on needs identified during the assessment, and on resources available to the youth. A visual summary of the services under PChAD is presented in Figure 2.

Figure 2: Services under PChAD



Highlights from the literature

A brief overview of the literature on the outcomes of mandated treatment was conducted in 2006 in an attempt to provide information to guide evidence-based practices (AADAC, 2006b). The review involved searches of several electronic databases (e.g., PsycINFO, MEDLINE), as well as Google searches and a book search at the Alberta Government Library using keywords such as mandatory treatment, detoxification, and child or adolescent for the time period 2000 to 2006. The review yielded the following observations:

- Limited research exists on the effectiveness of mandated treatment, and many of the published studies have methodological limitations.
- The results from 30 years of published research on mandatory drug treatment are inconclusive.
- Motivation, rather than coercion or mandated treatment, may play a more important role in the positive outcomes of substance abuse treatment.
- Although it is suggested that mandatory treatment clients are less motivated to change, motivation is a flexible characteristic. With readiness training, it is possible to improve client motivation to change.
- Legal pressure may enhance motivation, which leads to behaviour change.
- Among adolescents, pre-treatment substance use is predictive of post-treatment substance use.
- Treatment that incorporates both the individual adolescent and their environment are likely to have longer-lasting, more positive effects.
- It is possible that providing court-ordered treatment to at-risk youth may reduce criminal activity among this population, especially in populations that are over-represented in the justice system.

Evaluation methods

AADAC is committed to improving services provided to Albertans. Programs are based upon the best and most promising practices in the addictions field and careful monitoring of treatment services. Therefore, to ensure services under the PChAD legislation meet the needs of Albertans and are consistent with sound practice, AADAC commissioned Pivotal Research Inc. to conduct an evaluation of these services.

The purpose of the evaluation was to

- determine the effectiveness of implementing the services provided under PChAD
- evaluate the outcomes related to impact and effectiveness of the services
- provide recommendations to AADAC for the continued development and implementation of PChAD

To meet this purpose, Pivotal Research conducted the evaluation in three stages:

- evaluability assessment
- formative evaluation
- summative evaluation

From the evaluation findings of these three stages, recommendations were made for improving the program and achieving expected outcomes. A final technical report, entitled PChAD Act Evaluation (Pivotal Research Inc., 2007), was produced from the evaluation.

1. Evaluability assessment

The evaluability assessment, completed in December 2006, identified the feasibility of providing evaluation information to examine expected outcomes. This stage helped to inform what should be measured (e.g., indicators and data sources) to determine whether the implementation process was successful. Indicators were developed to provide ongoing feedback regarding the implementation, utilization and effectiveness of the PChAD services.

2. Formative evaluation

The formative evaluation, completed in March 2007, assessed the implementation of PChAD in terms of its effectiveness and areas for improvement to ensure the program was implemented as intended. Data were collected from December 2006 through February 2007. Methods used in the formative evaluation stage included

- site visits and in-person interviews with staff of the five protective safe houses in Edmonton, Calgary, Red Deer, Picture Butte and Grande Prairie
- in-person interviews with AADAC staff including counsellors and administrators located in towns and cities with a PSH, and with program development personnel including steering committee members and PSH managers
- telephone interviews with nine mobile staff located in Whitecourt, High Level, Athabasca, Brooks, Cold Lake, Medicine Hat, St. Paul, Barrhead and Camrose

Table 1 summarizes the number of respondents participating in the formative evaluation by staff role in PChAD.

Table 1: Respondents by PChAD role in formative evaluation

Personnel	Number of respondents
Protective safe house staff	18
Supervisors	5
Program directors	2
Child and youth workers	8
House parents	3
AADAC staff	23
Addictions counsellors	10
Administrators	4
Mobile staff	9
Program development personnel	8
Steering committee members	4
House managers	4
TOTAL	49

Additionally, telephone interviews were conducted with youth (n = 47) and parents (n = 49) within four days of discharge.

3. Summative evaluation

The summative evaluation, completed in July 2007, assessed the outcomes of the PChAD program from a client, clinical practice and management perspective. It identified performance measure indicators and benchmarks for ongoing evaluation.

Methods for the summative phase included gathering data from the AADAC System for Information and Service Tracking (ASIST) and a series of surveys conducted between December 2006 and June 2007. Program staff completed an online survey in April and again in June 2007. Forty-six staff completed the first survey, and 24 completed the second survey (see Table 2).

Participating youth and their parents were surveyed by telephone at the point of youth discharge from the PSH and at one month, three months and six months following discharge. The potential survey population at discharge was 329 individuals (youth and parents). Thirty individuals were removed from this population because of invalid consents. Of the remaining 299 potential participants, 244 individuals (93 youth and 151 parents) completed the discharge survey. Survey completion for the subsequent surveys was as follows: one month: 165 (53 youth and 112 parents); three months: 75 (21 youth and 54 parents); and six months: 14 (3 youth and 11 parents) (see Table 2).

Table 2: Summative evaluation survey completion

Staff online surveys		Subtotal	Total completed surveys
April-07		46	70
June-07		24	
Participant surveys		Subtotal	Total completed surveys
Discharge	Youth	93	244
	Parents	151	
One month after discharge	Youth	53	165
	Parents	112	
Three months after discharge	Youth	21	75
	Parents	54	
Six months after discharge	Youth	3	14
	Parents	11	

Evaluation challenges

Youth and parents were asked to fill out “consent for follow-up” forms as part of the discharge procedure. In response to a high rate of invalid consent forms early in the summative evaluation, Pivotal Research worked with PSH staff to increase the number of valid consent forms.

In general, parents were more likely than youth to participate in the surveys. For example, 90% of parents completed an interview at discharge, compared with 71% of youth. It is not possible to determine how the characteristics of non-participating youth differ from those involved in the evaluation.

Sometimes parents would not allow interviewers to speak with the youth for the follow-up survey, especially if the youth was female. Interviewers were unable to disclose the purpose of the survey to parents if they had not provided consent to be part of the survey process. Future recommendations include asking youth on the initial consent form whether interviewers may disclose the purpose of the survey to the parent. It is also recommended that as part of the discharge procedure, interviewers explain to youth and parents that the follow-up survey involves a four-part interview completed over six months.

Over time, the survey population declined as a result of several factors:

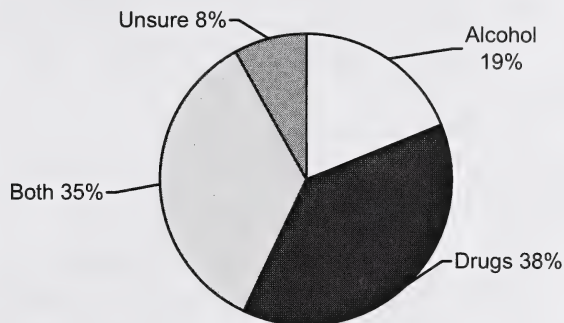
- Individuals who provided invalid consent forms and individuals who did not provide consent were removed from the sample.
- If data for one survey were not collected from an individual (e.g., discharge survey), that person was not to be contacted to complete the next survey (e.g., one month follow-up). This also applied to the staff survey. Only those program staff who completed the first survey in April (n = 46) were eligible to participate in the second survey in June (n = 24). Staff turnover in the protective safe houses was very high during the evaluation period, which accounted for the considerably lower response for the second survey.
- There was a decline because of timing attrition. The six-month follow-up group was small because the program had started so recently: few youth had been treated early enough for six months to have elapsed. Caution is urged in interpreting results.

Demographic information

The majority of youth who completed a survey were between the ages of 14 and 17, with a fairly even split between male and female respondents. This is consistent with data from ASIST regarding PChAD youth clients, suggesting that the evaluation sample was representative of the population.

The following figure shows that 92% of youth reported alcohol, other drugs or both as the reasons for being admitted to the PSH. Eight per cent were unsure of why they were at the PSH. Some youth do not initially define their use as problematic and thus do not report their use as the reason they are admitted to services under PChAD.

Figure 3: Reason youth was at PSH (n = 93)



Summary of key findings, implications and recommendations

This section highlights key findings of the evaluation based on outcomes and program delivery processes through four themes. The first three themes are determined from the expected outcomes grouped into indicator categories. The fourth theme is based on the processes put in place to ensure the intended outcomes are achieved throughout the administration of the program. These themes were developed during the evaluability assessment and refined for the summative evaluation:

- awareness, understanding and access
- implementation of PChAD services
- value of PChAD services
- program delivery of PChAD services

Each expected outcome is rated according to whether the PChAD services had “met,” the outcome, had made “good progress” toward the outcome, or had made “some progress” toward the outcome. Table 3 shows the results of the assessment of expected outcomes.

Table 3: Assessment of expected outcomes

Awareness, understanding and access			
<i>Expected outcome</i>	Met	Good progress	Some progress
Parents are aware of the intent of PChAD		X	
Parents access PChAD		X	
Parents perceive services provided through PChAD as timely	X		
Parents perceive services provided through PChAD as responsive	X		
Implementation of PChAD services			
<i>Expected outcome</i>	Met	Good progress	Some progress
Parents are satisfied with intake procedures	X		
Parents are satisfied with assessment procedures		X	
Parents are satisfied with treatment plan procedures ¹			X
Youth is satisfied with intake procedures	X		
Youth is satisfied with assessment procedures	X		
Youth is satisfied with treatment plan development		X	
Value of PChAD services			
<i>Expected outcome</i>	Met	Good progress	Some progress
Parents are satisfied with services provided through PChAD ²		X	
Parents reconnect with their child	X		
Youth is safe		X	
Youth reconnects with his/her family	X		
Youth satisfied with services provided through PChAD	X		
Youth follows the treatment plan and aftercare plan		X	
Youth has an increased quality of life	X		
Program delivery of PChAD services			
<i>Expected outcome</i>	Met	Good progress	Some progress
Child apprehended and transported safely to a protective safe house			X
Assessment completed in up to five days		X	
Transition plan in place after assessment		X	
Parents provided an opportunity to engage in additional support			X

1 As parent involvement in the treatment plan process decreases, satisfaction with the treatment plan process also diminishes.

2 Parents who are involved with follow-up are generally more satisfied with PChAD services over time.

In general, the expected outcomes were positive, with most outcomes being met or showing good progress. Table 3 highlights areas for improvement in which some progress was made. The following section reviews key findings in more detail.

Awareness, understanding and access

Because the PChAD program is a parent-driven service, measures of awareness, understanding and access were gathered from parent observations.

Measuring results through indexing

Although results are often reported as percentages, the researchers also used an index score calculation (the results of which are shown in parentheses). Indexing is a common practice with many applications; for example, indexes are used in health (BMI or body mass index), economics (GDP or gross domestic product) and education (GPA or grade point average). Each is calculated differently, but their uses are similar. Indexing enables statisticians to aggregate and compare data between variables or people. Typically, programs that perform well on any characteristic are those with an index score of 80 points or more.

Refer to the Appendix for further details.

- Seventy-seven per cent of parents were aware of the intent of PChAD.
- Of those parents whose expectations did not fit with the program intentions of PChAD, 64% also reported that the program did not meet their expectations.
- The majority of parents perceived services provided through PChAD as responsive, in terms of access to counsellors at the PSH (81)² and the 1-888 line (92).
- The majority of parents perceived services provided through PChAD as timely (89).

Measures indicating the greatest satisfaction from parents were timeliness of the service from application to admission, and the responsiveness of the services provided. Responsiveness included access to counsellors at the protective safe houses and the 1-888 line services. The 1-888 PChAD phone line is dedicated to the PChAD program. The line is used to notify AADAC of a guardian's intent to apply for a court order and to ask for an available bed once the court order has been granted. The line is also used to track available beds in the protective safe houses.

The majority of parents (77%) were aware of the intent of PChAD, as indicated by the following comment from one parent:

[He] would be in a safe environment, and he would not be able to use or have drugs around him. He would get some initial counselling and assessment to determine how severe his problem was.

Responses from the remaining 23% of parents suggest that some may have had expectations that did not fit or exceeded the intent of the program, as indicated by the following comment from one parent:

I expected them to do blood and urine tests and a physical, some type of medical screening... I expected them to begin some type of 12-step program.

Of those parents whose expectations did not fit with the intentions of PChAD, almost two-thirds (64%) also reported that the program did not meet their expectations. It is likely that the gap between expected and actual service provision contributed to parents' overall dissatisfaction with PChAD. The newness of the program and the many different sources of information may have contributed to confusion about the intent of PChAD. Parents reported

² Index score (see sidebar note and appendix for information on indexing)

I think that knowledge about the program in the community needs to be increased, as well as understanding of the act.

receiving information about the PChAD program from a number of sources, including the 1-888 line, AADAC offices, parent support groups, police, social services, word of mouth and other sources (e.g., media, schools, service organizations and the courts).

It is recommended that the communication process be reviewed to enhance parents' knowledge and expectations of PChAD.

Implementation of PChAD services

Measures of implementation of PChAD services were gathered from youth and parent feedback on three items: intake procedures, assessment procedures and treatment plan development.

- The majority of parents (87)³ and most youth (81) were satisfied with intake procedures.
- Parents were moderately satisfied (75) and the majority of youth were satisfied (85) with assessment procedures.
- Though youth were moderately satisfied with treatment plan development (78), significant proportions of parents were dissatisfied with treatment plan development (65).
- Seventy-seven per cent of parents were involved with treatment plan development and 63% were involved with follow-up.
- As parent involvement in the treatment planning process decreased, satisfaction with the treatment planning process also diminished.

In general, youth and parents were satisfied with intake and assessment procedures. Treatment plans had lower satisfaction levels: youth were moderately satisfied (78) and a significant number of parents were dissatisfied with treatment plan procedures (65). Nine per cent of youth reported that they did not participate in their treatment plan development. Furthermore, 23% of parents were not involved in the development of the treatment plan, and satisfaction was moderate (71) even for those who reported being "very involved." This is a significant observation, because it was shown in the evaluation that as parent involvement in the treatment planning process decreased, satisfaction with the treatment planning process also diminished.

It is recommended that future evaluations more fully explore the link between expectations, involvement in planning and follow-up, and satisfaction.

³ Unless otherwise noted, numbers in parentheses refer to index scores.

Value of PChAD services

The value of PChAD services was measured through multiple questions relating to safety, overall service satisfaction, quality of life and family reconnection.

- The majority of parents were satisfied with their child's safety while at a PSH (96).
- Most parents were satisfied with the services initially provided through PChAD (82), but satisfaction dropped off over time (to 77 one month after discharge and 70 three months after discharge).
- Eighty-five per cent of youth would recommend the services to friends or relatives in need.
- The majority of youth were satisfied with the services provided at discharge (83); this was sustained over time (87 one month after discharge and 91 three months after discharge).
- Fifty-eight per cent of youth indicated an improvement in their quality of life one month after discharge, and this percentage continued to increase over time.
- More than half of youth reported having a better relationship with their family following discharge.
- A key finding was that about half of youth (49%) who participated in the evaluation reported seeking treatment voluntarily after leaving the PSH.

Voluntary services after PChAD

A key aim of the mandatory treatment service is to encourage subsequent access to voluntary services. This was achieved: about half of youth (49%) sought voluntary services after leaving a protective safe house. Some continued with AADAC services (40%), whereas others sought help from other agencies (22%). Counselling was the most common type of treatment reported among youth.

Youth satisfaction with PChAD

Satisfaction with the services provided through PChAD was high, and in the case of youth, increased with time following discharge. (Satisfaction scores increased between discharge and one month after discharge, and increased again between one month and three months after discharge.) Furthermore, 85% of youth would recommend services to friends or relatives in similar need. Feedback from youth indicated that improvements could be made in the rooms and free-time activities. The potential need for improvement in free-time activities was highlighted when youth were asked how often they were bored at the PSH. About half of youth (51%) were bored sometimes, and 32% reported being bored most of the time.

It is recommended that evaluation of youth satisfaction continue as improvements are made to PChAD programming.

Parent satisfaction with PChAD

Most parents were satisfied with the services initially provided through PChAD (82)⁴, but satisfaction dropped off over time (to 77 one month after discharge and to 70 three months after discharge). Further investigation revealed that parents who were dissatisfied with services overall were also dissatisfied with the assessment procedures and the treatment planning process. Therefore, these two processes may be very influential in how parents perceive PChAD services.

It is recommended that the link between parental satisfaction and assessment and treatment planning processes be further investigated. Future evaluation should identify which aspects of the treatment planning process could be improved.

Parent involvement in follow-up services

Those parents involved with follow-up services were generally more satisfied with PChAD services over time. *Although follow-up services are not directly part of PChAD services*, they appear to influence parent satisfaction with PChAD. The relationship between parent involvement and satisfaction, although not directly linked to successful outcomes in substance use, is consistent with risk and protective factor research completed in AADAC showing that family connections can work to reduce risk factors or enhance protective factors related to youth substance use (AADAC, 2002).

It is recommended that the link between parent involvement in follow-up services and parent satisfaction be further investigated.

Increased quality of life

Positive observations were found in self-reported increased quality of life among youth. Table 4 shows the percentage of youth reporting life change one month after discharge. Over half of youth (58%) reported an overall increased quality of life.

⁴ Unless otherwise noted, numbers in parentheses refer to index scores.

Table 4: Youth reporting quality of life change one month after discharge

Attribute	Better (%)	Same (%)	Worse (%)
Relationship with family	66	30	4
Physical health	66	28	6
Use of free time	65	33	2
School situation	58	24	18
Legal situation	57	35	7
Self image	53	24	6
Financial situation	52	38	10
Employment situation	46	49	5
Total	58	35	7

Improved relationships

A significant number of families showed improved relationships: 77% of parents were involved in treatment planning and 63% were involved with follow-up. These findings were supported by feedback from youth who reported having improved relationships with their family following discharge.

Program delivery of PChAD services

Program delivery was assessed in this evaluation by the following outcomes: youth apprehended and transported safely to a protective safe house, assessment completed in up to five days, transition plan in place after assessment, and parent provided an opportunity to engage in additional support. The evaluation provided additional insight into the length of stay, legal system role and confidentiality provisions.

- Youth were transported safely to the PSH; however, there was some confusion about roles and responsibilities regarding transportation.
- Assessment could be completed in five days, except when a youth was admitted on a weekend or required more time for detoxification.
- Transition plans were in place after the assessment according to half of the staff.
- Parents were not satisfied with the availability of treatment programs (68) or other support in the community (68) for youth and the family to continue treatment after the youth was discharged. Parents indicated a need for more resources and more information about them.

Transportation

Youth were transported safely to the PSH; however, there was some confusion about roles and responsibilities regarding transportation. One written comment from a staff member suggested that parents should transport youth to the PSH. During the formative evaluation, six personnel felt that parents should be transporting youth to the PSH more often. One respondent indicated that improving communication should begin as soon as possible, and that by driving the child to a PSH, parents are beginning this process.

It is recommended that further assessment of transportation is required. More information is needed on the role of parents and law enforcement services in getting youth safely to a PSH.

Assessment and transition planning

Completing an assessment in up to five days is a main goal of the services under PChAD. Half of the staff surveyed agreed this could be done, but when youth are admitted on a weekend or if youth require extended periods of detoxification, staff are often unable to complete a full assessment.

As well, half of staff in April, and then only a third in June, reported that there was enough time to develop a discharge plan after the assessment. High staff turnover during the evaluation period may have contributed to this decrease

Availability of support and community resources

Following the five-day PChAD service, parents and youth were encouraged to engage in additional support. Most staff were satisfied that parents were provided with enough information to engage in additional support services. In surveys after discharge, many parents were not satisfied with the availability of support or treatment resources in the community, or the support for youth and family to continue treatment. Parents reported problems with follow-up, including a lack of resources and information about them.

Length of stay

Both parents and staff reported that five days was not long enough to complete the intended activities. Eighty-six per cent of youth opposed this opinion and felt that five days was sufficient. The majority of staff stated that five days was not enough time to complete intake, assessment and discharge planning. This was particularly important for young people who were detoxing over a period of two or three days. Two days were usually required to complete an accurate assessment and discharge planning could not be completed accurately until the assessment was complete. Accomplishing these responsibilities in five days proved to be difficult.

Staff further reported that youth did not recover from their anger with parents until one or two days after admission. Once they recovered from their anger, they began to open up to staff and share information; however, staff did not know about the accuracy of the information being provided, because there had not been enough time for youth to build a trusting relationship with the house staff. This difficulty was compounded by shift changes, because some youth did not see the same youth workers for the duration of their admission.

Further details about an appropriate amount of time were varied. Youth who indicated that five days was not enough generally supported a 14-day stay. During feedback, 20 parents said up to 10 days was appropriate, whereas 19 recommended a stay of longer than two weeks. Recommendations from staff for an appropriate length of stay ranged from five to 90 days. The most frequently recommended time frame was 10 to 15 days.

Legal system role

Staff found it difficult to plan for admissions with outstanding court orders. Some orders were granted with an expiration date and others were not. Expiration dates varied widely, from 36 hours to two weeks. Staff stated that some parents who have been granted an order will use it as a disciplinary tool by telling their child they will enforce the order if the young person does not adopt what the parents feel is acceptable behaviour. The number of outstanding court orders is a challenge to staff in planning.

Staff reported some inconsistencies in granting orders and reviews. This item varied by jurisdiction: in some areas, judges were reluctant to grant orders, especially if the youth did not attend court. Furthermore, some jurisdictions were more receptive to granting reviews and cancelling orders than others. As a result, some regions had a high number of successful reviews and in other regions, reviews were not heard.

Confidentiality

Confidentiality concerns from staff were also noted, particularly the ability of staff to provide information to parents. Although admission to the safe house is parent-driven, youth were given the opportunity to permit or deny information to parents. This was particularly difficult for parents who wanted to be involved in their child's treatment plan.

As previously noted, parental involvement was shown to be associated with greater satisfaction with treatment planning and overall program service. PChAD staff stated that youth rarely arrived at the safe house with only addiction issues; there were other familial issues that may contribute to the youth's actions. Restrictions on parental involvement may remove opportunities to provide family counselling or appropriate referrals.

It is recommended that program delivery challenges identified by youth, parents and staff be reviewed, including length of stay and confidentiality. All of these program delivery items relate to the length of stay and the time available to complete the program goals of information and assessment. Staff may require additional training to work with youth and families within the confines of AADAC's confidentiality policy.

Conclusions

Overall, the services administered under the Protection of Children Abusing Drugs Act were successful in providing another option to parents in their efforts to support youth dealing with substance use problems. In its first year of implementation, the program made great strides in providing assessment and information in a mandated setting, as indicated by high satisfaction levels among both parents and youth. As well, many youth continued further treatment in voluntary services and reported an improved quality of life in areas such as relationship with family, health, use of free time, school situation and legal situation.

The evaluation identified areas for improvement including parent satisfaction with treatment planning procedures, transportation of the youth to the protective safe house, and providing parents with an opportunity to engage in additional support after discharge. The program outcomes and recommendations identified in this evaluation report will be used for the ongoing implementation of PChAD services.

Phase II of the evaluation

AADAC continues monitoring and evaluating the services provided under the PChAD Act. Initial planning for the next phase of the evaluation is currently underway. It will focus on

- conducting a more in-depth evaluation of the outcomes related to the effectiveness of the services
- examining clients' perceptions regarding opportunities for prevention and access to resources by families before they reach the stage of a court order
- providing recommendations to AADAC for the continued development and provision of services related to PChAD

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Appendix

Researchers at Pivotal Research developed the indexing system used to calculate several of the statistics that appear in this report. This index has been in use for about 10 years. As described in the technical report from Pivotal Research (2007), the weight given each response option to a survey question or scale is noted below. Averaging the results based on the weights uses all the information contained in the responses to each question or scale.

Very satisfied	100
Somewhat satisfied	75
Somewhat dissatisfied	25
Very dissatisfied	0
Not applicable	(not included in calculation)

As further described in the technical report, “Index scores are calculated by multiplying each percentage response on the four-point scale by the corresponding index value, adding values together and dividing the total by 100” (Pivotal Research Inc., 2007, p. 18).

An example of index scores on two attributes taken from the technical report is shown below in Table 5.

Table 5: Example of indexing

	Attribute	
	Timeliness (n = 100)	Safety (n = 100)
Very satisfied	10%	80%
Somewhat satisfied	80%	10%
Somewhat dissatisfied	0%	10%
Very dissatisfied	10%	0%
Combined % satisfied	90%	90%
*Index score	70	90

* Calculation for Timeliness: $(10/100) \times 100 + (80/100) \times 75 + (10/100) \times 0 = 70$

* Calculation for Safety: $(80/100) \times 100 + (10/100) \times 75 + (10/100) \times 25 = 90$

As shown in the example, “The index scores discriminate between the two attributes with a score of 70 points for timeliness and 90 points for safety. Based on the index scores, safety is performing better than timeliness for the population sampled” (Pivotal Research Inc., 2007, p. 19).



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